Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ECTOR COUNTY HOSPITAL DISTRICT
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name
AMERICAN ZURICH INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-2753-01

MFDR Date Received
April 12, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria. Medicare would have allowed this facility $14,552.14 for the MAR at 200%. Based on their payment of $762.53, a supplemental payment of $13,789.61 is due."

Amount in Dispute: $13,789.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "According to Rule 133.307(c)(1)(A), dates of service from April 1 through April 10, 2010 were not timely filed with the Division. Therefore, those dates of service cannot be considered by the Division and should be dismissed. . . . The carrier asserts that the charges were appropriately reduced or denied based upon the denial codes and explanations identified in its EOBs. The carrier incorporates those denial codes and explanations into this response."

Response Submitted by: Flahive, Ogden & Latson, Post Office Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 1, 2010 to April 20, 2010	Outpatient Hospital Services	$13,789.61	$1,020.21

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.

3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 18 – DUPLICATE CLAIM/SERVICE.
   - 201 – A CHARGE WAS MADE FOR TWO EVALUATIONS/VISITS ON THE SAME DAY.
   - 370 – THIS HOSPITAL OUTPATIENT ALLOWANCE WAS CALCULATED ACCORDING TO THE APC RATE, PLUS A MARKUP.
   - 435 – PER NCCI EDITS, THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF THE COMPREHENSIVE PROCEDURE.
   - 618 – THE VALUE OF THIS PROCEDURE IS PACKAGED INTO THE PAYMENT OF OTHER SERVICES PERFORMED ON THE SAME DATE OF SERVICE.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The request for dispute resolution of services rendered on dates of service April 1, 2010 through April 11, 2010 was received by the Division on April 12, 2011. This date is later than one year after the dates of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file the request for dispute resolution of these services with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these services. Therefore, service dates April 1, 2010 through April 11, 2010 will not be considered in this review. However, the Division concludes that the request for dispute resolution of services rendered from April 12, 2010 through April 20, 2010 was submitted in accordance with the timely filing requirements of §133.307(c); therefore, the services rendered from April 12, 2010 through April 20, 2010 will be considered in this review.
2. Review of the submitted documentation finds insufficient information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

Date of service April 12, 2010

- Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $15.14. 125% of this amount is $18.93. The recommended payment is $18.93.
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.14. 125% of this amount is $13.93. The recommended payment is $13.93.
- Procedure code 85651 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.08. 125% of this amount is $6.35. The recommended payment is $6.35.
- Procedure code 86140 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $7.41. 125% of this amount is $9.26. The recommended payment is $9.26.
- Procedure code 96365 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0439, which, per OPPS Addendum A, has a payment rate of $126.78. This amount multiplied by 60% yields an unadjusted labor-related amount of $76.07. This amount multiplied by the annual wage index for this facility of 0.9836 yields an adjusted labor-related amount of $74.82. The non-labor related portion is 40% of the APC rate or $50.71. The sum of the labor and non-labor related amounts is $125.53. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service is $125.53. This amount multiplied by 200% yields a MAR of $251.06.
- Procedure code 96366 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $25.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.40. This amount multiplied by the annual wage index for this facility of 0.9836 yields an adjusted labor-related amount of $15.15. The non-labor related portion is 40% of the APC rate or $10.27. The sum of the labor and non-labor related amounts is $25.42. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service is $25.42. This amount multiplied by 200% yields a MAR of $50.84.
- Per Medicare policy, procedure code 99213 is unbundled. This procedure is a component service of procedure code 96365 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.

Date of service April 13, 2010

- Procedure code 96365 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0439, which, per OPPS Addendum A, has a payment rate of $126.78. This amount multiplied by 60% yields an unadjusted labor-related amount of $76.07. This amount multiplied by the annual wage index for this facility of 0.9836 yields an adjusted labor-related amount of $74.82. The non-labor related portion is 40% of the APC rate or $50.71. The sum of the labor and non-labor related amounts is $125.53. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service is $125.53. This amount multiplied by 200% yields a MAR of $251.06.
- Procedure code 96366 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified

under APC 0436, which, per OPPS Addendum A, has a payment rate of $25.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.40. This amount multiplied by the annual wage index for this facility of 0.9836 yields an adjusted labor-related amount of $15.15. The non-labor related portion is 40% of the APC rate or $10.27. The sum of the labor and non-labor related amounts is $25.42. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service is $25.42. This amount multiplied by 200% yields a MAR of $50.84.

- Per Medicare policy, procedure code 99213 is unbundled. This procedure is a component service of procedure code 96365 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code J3370 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J7040 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

Date of service April 14, 2010

- Procedure code 96365 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0439, which, per OPPS Addendum A, has a payment rate of $126.78. This amount multiplied by 60% yields an unadjusted labor-related amount of $76.07. This amount multiplied by the annual wage index for this facility of 0.9836 yields an adjusted labor-related amount of $74.82. The non-labor related portion is 40% of the APC rate or $50.71. The sum of the labor and non-labor related amounts is $125.53. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service is $125.53. This amount multiplied by 200% yields a MAR of $251.06.
- Procedure code 96366 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $25.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.40. This amount multiplied by the annual wage index for this facility of 0.9836 yields an adjusted labor-related amount of $15.15. The non-labor related portion is 40% of the APC rate or $10.27. The sum of the labor and non-labor related amounts is $25.42. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service is $25.42. This amount multiplied by 200% yields a MAR of $50.84.
- Per Medicare policy, procedure code 99213 is unbundled. This procedure is a component service of procedure code 96365 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code J3370 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J7040 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

Date of service April 15, 2010

- Procedure code 36592 has a status indicator of Q1, which denotes STVX-packaged codes; payment for this service is packaged into the payment for any other procedure with status indicator S, T, V, or X billed for the same date of service. This code may be separately payable only if no other such procedures are billed for the same date. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for procedure codes 96365 and 96366 billed on the same date of service. Separate reimbursement is not recommended.
- Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $15.14. 125% of this amount is $18.93. The recommended payment is $18.93.
- Procedure code 80202 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $19.40. 125% of this amount is $24.25. The recommended payment is $24.25.

- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.14. 125% of this amount is $13.93. The recommended payment is $13.93.
- Procedure code 85651 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.08. 125% of this amount is $6.35. The recommended payment is $6.35.
- Procedure code 86140 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $7.41. 125% of this amount is $9.26. The recommended payment is $9.26.
- Procedure code 96365 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0439, which, per OPPS Addendum A, has a payment rate of $126.78. This amount multiplied by 60% yields an unadjusted labor-related amount of $76.07. This amount multiplied by the annual wage index for this facility of 0.9836 yields an adjusted labor-related amount of $74.82. The non-labor related portion is 40% of the APC rate or $50.71. The sum of the labor and non-labor related amounts is $125.53. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service is $125.53. This amount multiplied by 200% yields a MAR of $251.06.
- Procedure code 96366 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $25.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.40. This amount multiplied by the annual wage index for this facility of 0.9836 yields an adjusted labor-related amount of $15.15. The non-labor related portion is 40% of the APC rate or $10.27. The sum of the labor and non-labor related amounts is $25.42. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service is $25.42. This amount multiplied by 200% yields a MAR of $50.84.
- Per Medicare policy, procedure code 99213 is unbundled. This procedure is a component service of procedure code 96365 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code J3370 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code J7040 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

Date of service April 16, 2010

- Procedure code 96365 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0439, which, per OPPS Addendum A, has a payment rate of $126.78. This amount multiplied by 60% yields an unadjusted labor-related amount of $76.07. This amount multiplied by the annual wage index for this facility of 0.9836 yields an adjusted labor-related amount of $74.82. The non-labor related portion is 40% of the APC rate or $50.71. The sum of the labor and non-labor related amounts is $125.53. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service is $125.53. This amount multiplied by 200% yields a MAR of $251.06.
- Procedure code 96366 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $25.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.40. This amount multiplied by the annual wage index for this facility of 0.9836 yields an adjusted labor-related amount of $15.15. The non-labor related portion is 40% of the APC rate or $10.27. The sum of the labor and non-labor related amounts is $25.42. The cost of

this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service is $25.42. This amount multiplied by 200% yields a MAR of $50.84.

- Per Medicare policy, procedure code 99213 is unbundled. This procedure is a component service of procedure code 96365 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.

Date of service April 20, 2010

- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.
- Procedure code 96372 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $25.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.40. This amount multiplied by the annual wage index for this facility of 0.9836 yields an adjusted labor-related amount of $15.15. The non-labor related portion is 40% of the APC rate or $10.27. The sum of the labor and non-labor related amounts is $25.42. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service is $25.42. This amount multiplied by 200% yields a MAR of $50.84.
- Per Medicare policy, procedure code 99213 is unbundled. This procedure is a component service of procedure code 96372 performed on the same date. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.

5. The total allowable reimbursement for the services in dispute is $1,685.28. This amount less the amount previously paid by the insurance carrier of $665.07 leaves an amount due to the requestor of $1,020.21. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,020.21.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,020.21, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	October 15, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.